BREAST CANCER SUPPORT FUND

breastcancersupportfund.ca
1002-39 Old Mill Road
Toronto M8X 1G6
P: 416-233-7410
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Application for the Meal Support Program

Dear Applicant,

Before you begin the process to apply to be enrolled in the Meal Support Program, please ensure you read the following carefully.

- **Applicants must be diagnosed with breast cancer and must be on *active treatment**
- We prioritize low-income applicants
- Application must be signed by a health care professional
- Participation in the Meal Support Program may be for 4 – 24 weeks, depending on treatment
- Participants are required to fill out a brief evaluation form every two weeks as well as a final one at the conclusion of the program
- Do not submit an application prior to conformation of your treatment plan

ACTIVE TREATMENT - for the purposes of this application - refers to surgery, chemotherapy and radiation and reconstruction.

HOW the Meal Support Program Works:

On the recommendation of a health care professional, you will be enrolled in our Meal Support Program - a program that offers prepared nutritious meals at no charge to you.

A local service provider will deliver seven dinners per week to you at no cost.

If you are a single parent, your children (under the age of 16), will be included in the program.

The application must be signed by you and a health care professional.

You will submit your application to the BREAST CANCER SUPPORT FUND by email to MSP@breastcancersupportfund.ca.

Once your application for enrollment has been approved, you will be notified by phone or email and may begin the process of ordering nutritious, prepared dinners from a tested and approved local service provider.

At the start of the program, you will be notified about the number of weeks you will be enrolled in the program. *Note: The number of weeks on the program is determined by your treatment.*

Meals will be delivered to your home or to the location where you are staying if you are from out of town.

The service provider will notify you by text about the delivery time of your meals.

***You will be required to fill out a brief evaluation form every two weeks while you are enrolled in the program as well as a final one at the conclusion of the program** *(Note: failure to fill out evaluation forms will result in your removal from the program).*

Out of Town Participants:

If you do not live in the community where you are receiving your treatment for breast cancer and travel from out of town, arrangements will be made to deliver to the location where you are staying.

*You will provide this information online when you are ordering your meals.

Out of town patients are provided with four dinners per week unless other arrangements are made.

It is up to patients in the program to notify the staff of the Inn or Lodge where they are staying about expected delivery of prepared meals.

Name of Inn, Lodge or Hotel:

_____

Address (required):

_____

Name of Staff (if possible):

_____

FAMILY INFORMATION

Name: _____ Date of birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email address: _____

Home phone: _____ Bus: _____ Cell: _____

Marital status: _____

Number of people living in household: _____ Relation to applicant: _____

Do you have children living with you in your home? ☐ Yes ☐ No

If yes, age of children: _____

Please check the one that applies to you:

☐ Caucasian
☐ Black
☐ Indigenous
☐ Asian
☐ Other

HEALTH INFORMATION

Date of Diagnosis: _____ Type of breast cancer: _____

Surgery: *(date and type of surgery(s))* _____

Chemotherapy: *(start date if known)*_____ complete by: _____

Radiation: *(start date if known)* _____ complete by: _____

Reconstructive surgery: (relevant dates) _____

Additional treatment required: _____

_____

FINANCIAL INFORMATION

MONTHLY HOUSEHOLD EXPENSES: *Provide other details here as needed.*

Rent or mortgage		
House taxes *(if applicable)*		
Groceries		
Utilities *(hydro, gas, water)*		
Cable/Internet/Phone		
Car payment		
Car insurance		
Outstanding loans		
House/Apt. insurance		
Other *(specify)*		
TOTAL		

MONTHLY INCOME: *(use either gross or net columns)*

Source of Income	Gross Amount	Net Amount
Salary		
Short or Long-Term Disability		
Employment Insurance		
EI Sick Benefits (15 weeks)		
Provincial Social Assistance (ie. Trillium or ODSP)		
CPP Pension		
CPP Disability Pension		
Child Tax Credit		
Alimony		
Rental Income		
Other		
TOTAL		

Your household income this year? _____

Your household income last year? _____

EMPLOYMENT HISTORY

Occupation: _____ Currently Employed: ☐ Yes ☐ No

When was your last day at work? (approximate date is ok) _____

When will you be returning to work? _____

HEALTH CARE PROFESSIONAL

I have read and reviewed this complete application and can confirm that this applicant is currently undergoing breast cancer treatment and would benefit from being enrolled in the Meal Support Program.

_____

Signature

Please PRINT name: _____

Phone number: _____ Email: _____

Date signed: _____

☐ Social Worker ☐ Doctor ☐ Nurse ☐ Psychologist ☐ Psychiatrist

☐ Spiritual Care Representative ☐ Cancer Patient Navigator ☐ Other

For inquiries or clarifications: email info@breastcancersupportfund.ca or call 416.233.7410

1. I understand that it is my responsibility to consider allergies when ordering meals and that BCSF is not responsible for any problems that may arise from the meals delivered from the service provider.
2. I confirm that the information on this form is accurate.
3. I authorize a representative from the Breast Cancer Support Fund to contact the health care professional listed on this form about me (if required).

APPLICANT signature: _____

Date: _____

How did you find out about the Canadian Breast Cancer Support Fund?
(ie: social worker at cancer centre, internet search, friend, etc...)

LASTLY, there are two ways YOU CAN HELP US help other patients:

When we send a THANK YOU to donors, we often include a TESTIMONIAL and/or information about the women we have supported.

Please indicate if we may contact you about sharing all or part of your story with breast cancer.

- ☐ Yes, I am willing to share all or part of my story. I understand I can share this information anonymously or be identified by first name, first and last name, city etc.
- ☐ You have my permission to contact me after this date: _____

(Please note that your privacy and anonymity will be respected).

AND/OR:

You can also help by writing a brief testimonial about your experience and how the support you received helped you and your family. *(Forward it by email or by mail)*

We are NOT funded by any government agencies.
We are a new charity run by volunteers and rely on the generosity of Canadians.

OUR PRIVACY POLICY

The Breast Cancer Support Fund (BCSF) is committed to protecting the privacy of the personal information of its constituents (applicants, donors, health care professionals and other stakeholders).

We have taken the necessary actions to ensure that our Policy on the rules for collection, use, disclosure, and retention of your personal health information, in any format (paper or electronic), is based on internationally recognized privacy principles.

BCSF adheres to the requirements of the Personal Health Information Protection Act (PHIPA).